7.05: continued

issue an order referring the issues to an independent hearing officer designated by the Commissioner to conduct adjudicatory proceedings pursuant to 801 CMR 1.02 *et seq.*, or the Commissioner or the designee may decide the issues after giving both the hospital and the Division reasonable notice and an opportunity to be heard on these issues. A decision on legal issues by the Commissioner or the designee shall constitute a final decision of the Division subject to judicial review under M.G.L. c. 30A, § 14.

(c) Conduct of Adjudicatory Proceeding. An adjudicatory proceeding referred to an independent hearing officer designated by the Commissioner shall be governed by 801 CMR 1.02 and 1.03. Such a proceeding also will be governed by the following rules and procedures:

1. An adjudicatory proceeding will address only those issues identified in the Commissioner's order referring the matter to an independent hearing officer.
2. The hearing officer will only consider evidence that was presented to the Division during administrative review, except in those extraordinary circumstances where the hospital can demonstrate that the evidence could not have been obtained or produced at the time of the administrative review.
3. Upon conclusion of the adjudicatory proceeding, the hearing officer will prepare and forward to the Commissioner or the designee a written, recommended decision of the Division. The recommended decision will address each of the issues cited in the Commissioner's order referring the matter to the hearing officer. The Commissioner or the Commissioner's designee may adopt, modify or order reconsideration of the hearing officer's recommended decision.
4. The Commissioner will issue the final decision of the Division subject to judicial review under M.G.L. c. 30A, § 14.

7.10: Documentation and Audit: Free Care Accounts

(1) Each hospital shall maintain auditable records of its activities made in compliance with the criteria and requirements of regulation 114.6 CMR 7.00. The hospital shall document free care write-offs as reported on the RSC-403, DHCFP Form UC-92, DHCFP Form UC-93 or any successor form, or any other report that has been filed with the Division. . Each hospital's free care write-offs, shall be accompanied, at a minimum, by documentation of all efforts made by the hospital to determine free care eligibility.

(2) Documentation for free care accounts must conform to the requirements set forth in 114.6 CMR 10.00.

(3) If a hospital fails to meet the requirements of 114.6 CMR 7.00 or 114.6 CMR 10.00, the Division may adjust the hospital's payments from the uncompensated care pool.

(4) The Division's audit procedures regarding free care accounts and the Division's schedule of audit adjustments regarding deficiencies in documentation shall be detailed in a separate administrative information bulletin issued pursuant to 114.6 CMR 7.12. The audit adjustments will reflect the degree of non-compliance with the Division's criteria for documentation of free care accounts.

(5) The Division will determine the level of payment that will be disallowed from the Pool using a methodology to appropriately extrapolate the amount of audited accounts that fail to comply with 114.6 CMR 7.00 as compared to all of the hospital's or community health center's free care accounts.

7.12: Administrative Information Bulletins

The Division may, from time to time, issue administrative information bulletins to clarify its policy upon and understanding of substantive provisions of 114.6 CMR 7.00. In addition, the Division may issue administrative information bulletins which specify the information and documentation necessary to implement 114.6 CMR 7.00.

7.13: Severability

The provisions of 114.6 CMR 7.00 are hereby declared to be severable if any such provisions or the application of such provisions to any hospital or circumstances shall be held to be invalid or unconstitutional, and such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 114.6 CMR 7.00 or the application of such provisions to hospitals or circumstances other than those held invalid.

7.14: Calculation of the Uncompensated Care Pool Surcharge Percentage

The Division will use the following methodology to calculate the percentage of the surcharge to be assessed on certain payments to acute hospitals and ambulatory surgical centers, established in M.G.L. c. 118G, § 18A, as added by St. 1997, c. 47.

(1) The Division will project FY 98 annual aggregate payments subject to the surcharge as follows. The following data will be obtained for Pool FY 96, or adjusted for inflation to Pool FY 96:

(a) The Division will determine total payments received by Massachusetts acute care hospitals from private managed care, non-managed care, and self-pay payers by subtracting bad debt written off and gross payments from the Pool allocated to those payers from net patient service revenue allocated to those payers, as reported on the DHCFP-403 cost report.

(b) The Division will determine total payments received by Massachusetts ambulatory surgical centers for ambulatory surgical center services from private managed care, non-managed care, and self-pay payers from data reported by these centers to the Division.

(c) The Division will determine payments from HMOs licensed in Massachusetts to Massachusetts acute care hospitals and ambulatory surgical centers that are exempt from the surcharge from data provided by these HMOs to the Division.

(d) The Division will estimate the amount of payments, settlements and judgments arising out of third party liability claims for bodily injury which are paid under the terms of property or casualty insurance policies based on data provided by the Auto Insurers Bureau.

(e) The Division will estimate the amount of surcharge payments that will be below the threshold for collection based on sample data provided by hospitals.

(f) The Division will make an allowance for uncollectable amounts.

(g) The Division will add the amounts determined in 114.6 CMR 7.14(1)(a) and (b), and then subtract the amounts determined in 114.6 CMR 7.14(1)(c), (d), (e), and (f). The Division will then adjust this total amount of FY 96 payments subject to the surcharge to reflect price changes between FY 96 and FY 98. The Division will use a blend of the HCFA market basket and the Massachusetts Consumer Price Index (CPI) to reflect conditions in the Massachusetts economy. Specifically, the labor-related component of the HCFA market basket will be replaced by the CPI. This adjusted amount will be the Division's projected FY 98 annual aggregate payments subject to the surcharge.

(2) The Division will calculate the surcharge percentage effective January 1, 1998 as follows, in order to ensure that the amount loaned to the Pool will be fully repaid to the General Fund by June 30, 1998.

(a) The Division will multiply $100,000,000 by 2/12 and add this product to $100,000,000, in order to account for the two month delay in payment of the surcharge.

(b) The Division will multiply the projected FY 98 annual aggregate payments subject to the surcharge, determined pursuant to 114.6 CMR 7.14(1), by 9/12, in order to collect the full amount of the surcharge in nine months.

(c) The Division will divide the amount determined in 114.6 CMR 7.14(2)(a) by the amount determined in 114.6 CMR 7.14(2)(b).

This calculation can be expressed as the following formula.

PAAPSS = projected annual aggregate payments subject to the surcharge

Surcharge percentage effective January 1, 1998 =

[100,000,000 + ((2/12)*100,000,000)] / [(9/12) * FY 98 PAAPSS]

7.14: continued

(3) If the Division projects that the surcharge percentage established in 114.6 CMR 7.14(2) will produce less than $90,000,000 or more than $100,000,000 by September 30, 1998, or that an adjustment is necessary in order to fully repay the General Fund by June 30, 1998 then the division may redetermine the surcharge percentage as of May 1, 1998 and as of July 1, 1998 pursuant to the methodology established in 114.6 CMR 7.14(3)(a) through (d).

(a) The Division will project FY 98 annual aggregate payments subject to the surcharge based on historical data, with any adjustments the Divisions deems necessary.

(b) The Division will multiply $100,000,000 by 2/12 and add this product to $100,000,000, in order to account for the two month delay in payment of the surcharge.

(c) The Division will multiply the projected FY 98 annual aggregate payments subject to the surcharge, determined pursuant to 114.6 CMR 7.14(3)(a), by 9/12, in order to collect the full amount of the surcharge in nine months.

(d) The Division will divide the amount determined in 114.6 CMR 7.14(3)(b) by the amount determined in 114.6 CMR 7.14(2)(c).

This calculation can be expressed as the following formula.

PAAPSS = projected annual aggregate payments subject to the surcharge

Surcharge percentage effective May 1, 1998 or July 1, 1998 =

[100,000,000 + ((2/12)*100,000,000)] / [(9/12) * FY 98 PAAPSS]

(4) The Division will establish the surcharge percentage effective October 1 of 1998 and each successive year before September 1 of each year, using the following methodology.

(a) The Division will determine the total amount to be collected by adjusting $100,000,000 for any over or under collections from frequent payers and individuals in previous years, including audit adjustments, as well as any over or under collections projected for October or November of the coming year.

(b) The Division will project annual aggregate payments subject to the surcharge based on historical data, with any adjustments the Division deems necessary.

(c) The Division will divide the amount determined in 114.6 CMR 7.14(4)(a) by the amount determined in 114.6 CMR 7.14(4)(b).

7.15: Uncompensated Care Pool Surcharge Payment Process

(1) There is a surcharge on payments subject to surcharge as defined in 114.6 CMR 7.02. The surcharge shall be distinct from any other amount paid by a surcharge payer, as defined in 114.6 CMR 7.02, for the services provided by an acute care hospital or ambulatory surgical center. The surcharge amount shall equal the product of:

(a) the surcharge percentage calculated in 114.6 CMR 7.14; and

(b) payments subject to surcharge made by a surcharge payer.

Surcharge amounts paid shall be deposited in the Uncompensated Care Pool.

(2) Billing.

(a) Each acute hospital and ambulatory surgical center shall send a bill for the Uncompensated Care Pool surcharge to surcharge payers as required by M.G.L. c. 118G, § 18A(b). Hospitals and ambulatory surgical centers shall send this bill to surcharge payers from whom they have received payment for services in the most recent four quarters for which data is available. The bill will state the surcharge percentage, but not the dollar amount owed. The bill shall include notification of the surcharge payment process set forth in below, as well as a registration form specified by the Division. Hospitals and ambulatory surgical centers shall send this bill to payers before December 3, 1997, before September 1 of each successive year and before the effective date of any surcharge percentage calculated pursuant to 114.6 CMR 7.14(3).

7.15: continued

(b) Each acute hospital and ambulatory surgical center shall also send a bill for the surcharge to institutional surcharge payers that have not registered with the Division pursuant to 114.6 CMR 7.15(3) and (4) and from whom the hospital or ambulatory surgical center has received a payment. The hospital or ambulatory surgical center shall send the bill within 30 days of receiving the payment from the unregistered payer. The bill will state the surcharge percentage, but not the dollar amount owed.

(c) Each acute hospital and ambulatory surgical center shall send a bill for the surcharge to individual surcharge payers as provided in 114.3 CMR 7.15(5).

(3) Payment process for frequent surcharge payers.

(a) Frequent payers are institutional surcharge payers whose total payments to Massachusetts acute hospitals and ambulatory surgical centers in the most recently completed calendar year exceeded $300,000. Surcharge payers that are the successor in interest to a payer whose total payments to Massachusetts acute hospitals and ambulatory surgical centers in the most recently completed calendar year exceeded $300,000 are also frequent payers.

(b) Frequent payers must register with the Division or its agent by completing and submitting the Uncompensated Care Pool Surcharge Payer Registration form. Frequent payers shall submit this form to the Division or its agent before December 10, 1997 for Pool fiscal year 1998; before October 1, 1998 for Pool fiscal year 1999; and before each successive October 1 for future Pool years.

(c) After the end of each calendar month, each frequent payer shall determine the surcharge amount it owes to the Pool for that month. The amount owed shall be determined by multiplying the amount of payments subject to surcharge, as defined in 114.6 CMR 7.02, by the surcharge percentage in effect during that month. The frequent payer may adjust the surcharge owed for any surcharge over- or under-payments in a previous period.

1. Frequent payers that pay a global fee or capitation for services that include acute hospital or ambulatory surgical services, as well as other services not subject to the surcharge, must develop a reasonable method for allocating the portion of the payment intended to be used for services provided by acute hospitals or ambulatory surgical centers. Such frequent payers must file this allocation method with the Division or its agent before January 1, 1998 for Pool fiscal year 1998; before October 1, 1998 for Pool fiscal year 1999; and before each successive October 1 for future Pool years. If there is a significant change in the global fee or capitation payment arrangement that necessitates a change in the allocation method, the frequent payer must file the new method with the Division before the new payment arrangement takes effect. Frequent payers may not change the allocation method later in the year unless there is a significant change in the payment arrangement.

The Division will review allocation plans within 90 days of receipt. During this review period, the Division or its agent may require a frequent payer to submit supporting documentation or to make changes in this allocation method if it finds that the method does not reasonably allocate the portion of the global payment or capitation intended to be used for services provided by acute hospitals or ambulatory surgical centers.

A frequent payer must include the portion of the global payment or capitation intended to be used for services provided by acute hospitals or ambulatory surgical centers, as determined by this allocation method, in its determination of payments subject to surcharge.

2. A frequent payer must include all payments made as a result of settlements, judgments or audits in its determination of payments subject to surcharge. A frequent payer may include payments made by Massachusetts acute hospitals or ambulatory surgical centers to the frequent payer as a result of settlements, judgments or audits as a credit in its determination of payments subject to surcharge.

(d) Frequent payers shall make payments to the Pool monthly. Each frequent payer shall remit the surcharge amount it owes to the Pool, which it determined pursuant to 114.6 CMR 7.15(3)(c), to the Division or its agent for deposit in the Pool. Frequent payers shall remit the surcharge payment by the first business day of the second month following the month for which the surcharge amount was determined. For example, surcharge payments based on payments made to acute hospitals and ambulatory surgical centers in January are due to the Pool on March 1.

7.15: continued

(e) Estimated payments. In order to ensure that the Pool can meet its current obligations, frequent payers will make estimated payments to the Pool in January and February, 1998. These payments will be made to the Pool and credited to the payer as follows.

1. On January 5, 1998 each frequent surcharge payer shall make an estimated payment to the Pool equal to the product of the surcharge percentage and the payer's actual payments to Massachusetts acute hospitals and ambulatory surgical centers in January, 1997. If a surcharge payer has different clients in 1998 than in 1997, the surcharge payer may calculate its estimated payments by multiplying the surcharge percentage by the amount that its payments subject to surcharge would have been in January, 1997 if it had had its current set of clients.

2. On February 2, 1998 each frequent surcharge payer shall make an estimated payment to the Pool equal to the product of the surcharge percentage and the payer's actual payments subject to surcharge to Massachusetts acute hospitals and ambulatory surgical centers in February, 1997. If a surcharge payer has different clients in 1998 than in 1997, the surcharge payer may calculate its estimated payments by multiplying the surcharge percentage by the amount that its payments subject to surcharge would have been in February, 1997 if it had had its current set of clients.

3. Each frequent surcharge payer shall total the amounts it paid pursuant to 114.6 CMR 17.15(3)(e)1. and 2., and divide this total by five. The surcharge payer shall then credit this amount against each of the payments it makes from July, 1998 through November, 1998 pursuant to 114.6 CMR 17.15(3)(d).

(f) All payments must be payable in United States dollars and drawn on a United States bank. The Division will assess a $30 penalty on any surcharge payer whose check is returned for insufficient funds.

(4) Payment process for infrequent surcharge payers.

(a) Infrequent payers are institutional surcharge payers whose total payments to Massachusetts acute hospitals and ambulatory surgical centers in the most recently completed calendar year were less than $300,000.

(b) Before December 1, 1997 and before each September 1 thereafter, the Division will estimate the average annual surcharge liability of infrequent payers for the coming Pool fiscal year. For Pool years 1998 and beyond, the Division will adjust the estimated average surcharge liability for any over or under collections from infrequent payers in previous years.

(c) Infrequent payers may elect to pay the estimated average surcharge liability, determined by the Division pursuant to 114.6 CMR 7.15(4)(b), as a single annual payment. Infrequent payers who make this election shall have no further surcharge liability for the remainder of the Pool year, and shall have all reporting requirements waived for that year.

(d) Infrequent payers elect to pay the estimated average surcharge liability fee and waive reporting requirements by completing and submitting the Uncompensated Care Pool Surcharge Payer Registration form. Infrequent payers must submit this form to the Division or its agent before December 10, 1998 for Pool fiscal year 1998; before October 1, 1998 for Pool fiscal year 1999; and before each successive October 1 for future Pool years. Infrequent payers must pay the estimate average surcharge liability by January 15, 1998 for Pool year 1998, and by November 1 for each successive Pool year.

(e) Infrequent payers who do not elect to pay the estimated average surcharge liability are subject to the same requirements as frequent payers, set forth in 114.6 CMR 7.15(3).

(f) All payments must be payable in United States dollars and drawn on a United States bank. The Division will assess a $30 penalty on any surcharge payer whose check is returned for insufficient funds.

(g) The Division will review the effects of the infrequent payer option before September 1, 1998.

(5) Individual surcharge payers (Self-pay).

(a) Payments made by an individual surcharge payer of $15,000 or more after January 1, 1998 and of $10,000 or more after April 1, 1998 are subject to the surcharge. Acute hospitals and ambulatory surgical centers shall, at the time of billing, provide notice of the responsibility to pay the surcharge and the surcharge amount on all bills to individual payers with a patient liability greater than the threshold. The surcharge bill shall direct patients to pay the surcharge to the hospital or ambulatory surgical center in addition to the payment for services provided. The amount of the surcharge billed is the product of:

7.15: continued

1. the patient's liability to the acute hospital or ambulatory surgical center, and
2. the surcharge percentage, established pursuant to 114.6 CMR 7.14, in effect on the billing date.

(b) In the event that an acute hospital or ambulatory surgical center negotiates a payment amount or payment plan for a total payment in excess of the threshold amount established in 114.6 CMR 7.15(5)(a), the negotiation must address payment of the surcharge amount owed, pursuant to 114.6 CMR 7.15(5)(c).

(c) The amount of the surcharge owed by an individual payer is the product of:

1. the total amount paid by the individual to an acute hospital or ambulatory surgical center, and
2. the surcharge percentage, established pursuant to 114.6 CMR 7.14, in effect on the payment date.

(d) Acute hospitals and ambulatory surgical centers shall forward surcharge payments received from individual payers to the Division or its agent for deposit in the Pool. Acute hospitals may deduct collection agency fees for the collection of surcharge payments from individuals from the total amount of surcharge payments forwarded to the Pool.

Acute hospitals and ambulatory surgical centers shall forward surcharge payments by the first business day of the second month following the month during which the surcharge was received. For example, surcharge payments received by acute hospitals and ambulatory surgical centers in January are due to the Pool on March 1.

(e) An acute hospital or ambulatory surgical center which fails to forward surcharge payments received from individual payers pursuant to 114.6 CMR 7.15(5)(e) is subject to the enforcement mechanisms set forth in 114.6 CMR 7.15(7).

(f) All payments must be payable in United States dollars and drawn on a United States bank. The Division will assess a $30 penalty on any surcharge payer whose check is returned for insufficient funds.

(g) The Division will review the threshold established in 114.6 CMR 7.15 (5)(a) before September 1, 1998.

(6) The Division or its agent will compile lists of registered frequent and infrequent payers, and will update the lists quarterly. The Division or its agent will distribute these lists to acute hospitals and ambulatory surgical centers.

(7) Enforcement of payment of the surcharge.

(a) If any part of a surcharge payer's liability is not paid within ten days of the due date, the surcharge payer shall owe an additional 1.5% interest penalty on the outstanding balance. The interest shall be calculated from the due date. For each month a payment remains delinquent, an additional 1.5% penalty shall accrue against the outstanding balance, including prior penalties.

1. Partial payments received from delinquent surcharge payers shall be credited first to the current outstanding liability, and second to the amount of the penalties.
2. The Division may reduce a surcharge payer's penalty at the Division's discretion. In determining a waiver or reduction, the Division's consideration will include, but will not be limited to, the surcharge payer's payment history, the surcharge payer's financial situation, and the surcharge payer's relative share of the payments to the Uncompensated Care Pool.

(b) In the event that the Division or its agent does not receive a payer's payment within 35 days, the Division or its agent may assess an estimated amount due, based on the best data available, plus the interest penalties described in 114.6 CMR 7.15(7)(a), plus a 5% late fee on the outstanding amount. The minimum amount assessed will be $100.

(c) Division of Medical Assistance (DMA) payment offset. In the event that a surcharge payer has maintained an outstanding obligation to the Pool for more than 45 days, the Division may notify DMA to offset payments on the claims of the surcharge payer, any entity under common ownership, as defined in 130 CMR 450.00, or any successor in interest to the surcharge payer, in the amount of payment owed to the Pool, including accrued interest penalties and late fee. Payments offset in accordance with this provision shall be credited to the surcharge payer's outstanding liability to the Pool.

1. The Division shall notify the surcharge payer in writing of the dollar amount to be offset from the surcharge payer's DMA claims. Such notification shall be sent to the surcharge payer via certified mail at least ten days prior to notifying DMA.

7.15: continued

a. If a surcharge payer believes the amount to be offset is incorrect because of an arithmetic, mechanical or clerical error, it may object in writing during this ten day period to the Division of Health Care Finance and Policy. The written objection must contain an explanation of the perceived error as well as documentation to support the surcharge payer's objection. No objection by the surcharge payer regarding the payment offset is appealable to DMA.

b. Upon review of the surcharge payer's objections, the Division shall notify the surcharge payer of its determination in writing. If the Division disagrees with the surcharge payer's objections, in whole or in part, the Division shall provide the surcharge payer with an explanation of its reasoning.

2. The Division shall notify DMA in writing of the dollar amount to be offset from the surcharge payer's DMA claims.

3. Surcharge payers to which payment is offset must serve all Title XIX recipients in accordance with the contract then in effect with the Division of Medical Assistance.

(d) Payment schedules: Where a financial hardship is determined, the Division may, at its discretion, establish a payment schedule for a given surcharge payer. The payment schedule may include an interest charge.

1. The interest rate used for the payment schedule shall not exceed the prime rate plus 2%. The prime rate used shall be the rate reported in the *Wall Street Journal* dated the last business day of the month preceding the establishment of the payment schedule.

2. A surcharge payer may make a full or partial payment of its outstanding liability at any time without penalty.

3. If a surcharge payer fails to meet the obligations of the payment schedule, the Division may assess penalties pursuant to 114.6 CMR 7.15(7).

7.16: Reporting Requirements for Surcharge Payers

(1) Each surcharge payer shall submit an annual report to the Division or its agent containing data regarding their payments to acute hospitals and ambulatory surgical centers in the previous year, payments exempt from surcharge adjustments it made for over- or under-payments of the surcharge, and any other information necessary to calculate the surcharge amount owed. This data must be submitted in an electronic format specified by the Division.

(2) Each surcharge payer shall file or make available information which is required by 114.6 CMR 7.16 or which the Division deems reasonably necessary for implementation of 114.6 CMR 7.00, within 15 days from the date of request from the Division, unless a different time is specified in the request. The Division may, for cause, extend the filing date for the submission of data. Any request for an extension must be made in writing and submitted to the Division in advance of the filing date.

(3) Any surcharge payer that qualifies for infrequent payer status, registers with the Division or its agent and pays the estimated average surcharge liability, pursuant to 114.6 CMR 7.15(4) shall be exempt from the provisions of 114.6 CMR 7.16(1) and (2). Individual payers are exempt from the requirements of 114.6 CMR 7.16.

(4) Any surcharge payer which fails to file any data, statistics, schedules, or other information pursuant to 114.6 CMR 7.00 or which falsifies same, shall be subject to a civil penalty of not more than $5000 for each day on which such violation occurs or continues, which penalty may be assessed in an action brought on behalf of the Commonwealth in any court of competent jurisdiction. The Attorney General shall bring any appropriate action, including injunction relief, as may be necessary for the enforcement of the provisions of 114.6 CMR 7.00.

(5) A surcharge payer that is a third party administrator that makes payments to hospitals and ambulatory surgical centers on behalf of one or more insurance carriers will file a monthly report with the Division. The report will include the surcharge amounts that the third party administrator paid on behalf of each insurance carrier, and on behalf of all its self-insured clients combined. The report will be in an electronic format specified by the Division.

Third party administrators shall submit this data by the first business day of the second month following the month during which the payment was received. For example, data regarding payments received in January is due to the Division or its agent on March 1.

7.17: Administrative Review for Surcharge Payers

The Division may conduct an administrative review at any time.

(1) The Division will review data submitted by acute hospitals pursuant to 114.6 CMR 7.03(1)(f), data submitted by ambulatory surgical centers pursuant to 114.6 CMR 7.18, data submitted by frequent surcharge payers pursuant to 114.6 CMR 7.16, the Uncompensated Care Pool Surcharge Payer Registration form submitted by frequent payers pursuant to 114.6 CMR 7.15(3) and by infrequent payers pursuant to 114.6 CMR 7.15(4), and any other pertinent data. All information provided by, or required from, any surcharge payer, pursuant to 114.6 CMR 7.00 shall be subject to audit by the Division.

For surcharge payments based upon a global fee or capitation allocated according to an allocation method accepted by the Division pursuant to 114.6 CMR 7.15(3)(c)1., the Division's review will be limited to determining whether this method was followed accurately and whether the amounts reported were accurate.

(2) If the Division determines through its review that a surcharge payer's payment to the Pool was materially incorrect, the Division:

(a) may require the surcharge payer to submit additional documentation reconciling the data it submitted with data received from hospitals; and

(b) may require a payment adjustment. Payment adjustments shall be subject to interest penalties and late fee, pursuant to 114.6 CMR 7.15(7), from the date the original payment was owed to the Pool.

Payment adjustments may also be offset from Division of Medical Assistance payments, pursuant to 114.6 CMR 7.15(7).

(3) Processing of Payment Adjustments.

(a) Notification. The Division shall notify a surcharge payer of its proposed adjustments. The notification shall be in writing and shall contain a complete listing of all proposed adjustments as well as the Division's explanation for each adjustment.

(b) Objection Process.

1. If a surcharge payer wishes to object to a Division proposed adjustment contained in the notification letter issued pursuant to 114.6 CMR 7.17(3)(a), it must do so in writing, within 15 business days of the mailing of the notification letter. The surcharge payer may request an extension of this period for cause.

2. The written objection must, at a minimum, contain:
   a. each adjustment to which the surcharge payer is objecting,
   b. the fiscal year for each disputed adjustment,
   c. the specific reason for each objection, and
   d. all documentation which supports the surcharge payer's position.

3. Upon review of the surcharge payer's objections, the Division shall notify the surcharge payer of its determination in writing. If the Division disagrees with the surcharge payer's objections, in whole or in part, the Division shall provide the surcharge payer with an explanation of its reasoning.

4. The surcharge payer may request a conference on objections after receiving the Division's explanation of reasons as required under 114.6 CMR 7.17(3)(b)3. The Division will schedule such conference on objections only when it believes that further articulation of the surcharge payer's position is beneficial to the resolution of the disputed adjustments.

(c) Payment of Adjustment Amounts. Adjustment amounts and any interest penalty and late fee amounts shall be due to the Pool 30 calendar days following the mailing of the Notification letter issued pursuant to 114.6 CMR 7.17(3)(a). If the surcharge payer submitted a written objection, then adjustment amounts and any interest penalty and late fee amounts shall be due to the Pool 30 calendar days following the mailing of the Division's determination issued pursuant to 114.6 CMR 7.17(3)(b)3. The Division may establish a payment schedule for adjustment amounts, pursuant to 114.6 CMR 7.15(7)(d).

7.18: Reporting Requirements for Ambulatory Surgical Centers

(1) Each ambulatory surgical center shall report monthly to the Division or its agent the total amount of payments for services received from surcharge payers, other than individual payers, who do not appear on either the frequent or infrequent payer list and the amount of surcharge payments received from individuals. Ambulatory surgical centers must report this data in an electronic format specified by the Division.

Ambulatory surgical centers shall submit this data by the first business day of the second month following the month during which the payment was received. For example, data regarding payments received in January is due to the Division or its agent on March 1.

(2) Each ambulatory surgical center shall report annually to the Division or its agent the total amount of payments received from surcharge payers. The Division may waive reporting on payers whose payments to the hospital do not meet a threshold amount. Ambulatory surgical centers shall report this data in an electronic format specified by the Division.

(3) Each ambulatory surgical center shall file or make available information which is required by 114.6 CMR 7.18 or which the Division deems reasonably necessary for implementation of 114.6 CMR 7.00, within 15 days from the date of request from the Division, unless a different time is specified in the request. The Division may, for cause, extend the filing date for the submission of data. Any request for an extension must be made in writing and submitted to the Division in advance of the filing date.

(4) An ambulatory surgical center that knowingly fails to file with the Division any data required by 114.6 CMR 7.18 or knowingly falsifies the same shall be subject to a $500.00 fine.

(5) The Division may audit data submitted by ambulatory surgical centers to ensure accuracy.

REGULATORY AUTHORITY

114.6 CMR 7.00: M.G.L. c. 118G.

TN 98-12
STATE PLAN AMENDMENT EXHIBITS
INPATIENT ACUTE HOSPITAL

Exhibit 6:
105 CMR 160.000
114.3 CMR 46.00

105 CMR 160.000: ACUTE CARE INPATIENT SUBSTANCE ABUSE DETOXIFICATION TREATMENT SERVICES

Section

Section: continued

160.001: Purpose

105 CMR 160.000 sets forth standards for the maintenance and operation of acute care inpatient substance abuse detoxification treatment services.

160.002: Authority

105 CMR 160.000 is adopted under the authority of M.G.L. c. 111B, § 6 and c. 111E, § 7.

160.003: Citation

105 CMR 160.000 shall be known and may be cited as 105 CMR 160.000: *Acute Care Inpatient Substance Abuse Detoxification Treatment Services.*

160.004: Scope

105 CMR 160.000 replaces and shall be substituted for 105 CMR 160.000 and shall be substituted for 105 CMR 750.700(B) for all residential detoxification programs and shall apply to all entities which provide acute care inpatient substance abuse detoxification treatment services.

All references to residential detoxification programs in 105 CMR 750.000, including sections; 750.010, 750.020, 750.500(D)(2), 750.540(E) and 750.800(C)(1) are hereby deleted. Such entities are subject to licensure or approval under M.G.L. c. 111B, § 6 and c.111E, § 7.

160.020: Definitions

The following definitions shall apply for the purpose of 105 CMR 160.000 unless the context or subject matter clearly requires a different interpretation.

Acute Care Inpatient Substance Abuse Detoxification Treatment Service an inpatient unit that provides short term medical treatment for alcohol and other drug withdrawal, individual medical assessment, evaluation, intervention, substance abuse counseling and post detoxification referrals. The units may be freestanding or hospital based programs.

Administrator The individual duly appointed by the governing body of the agency who is responsible for the day to day operations of the agency operating the service.

Affiliation Agreement shall mean a signed and dated document describing the agreed upon terms of a service relationship between the named parties.

Agency shall mean a legal entity to which a license or approval is granted by the Department for the delivery of the service.

Approval shall mean a certification, in writing, whether full or provisional, issued by the Department to a private or public entity or institution thereof which authorizes it to operate the service.

Building shall mean the physical structure in which the service is provided.

Clinical Supervisor shall mean an individual with a minimum of a doctorate or masters degree in one of the following disciplines or a closely related field: clinical psychology education-counseling, medicine, psychology, nursing, rehabilitative counseling, social work; or a licensed certified social worker; a minimum of one year of clinical supervisory experience and three years of counseling experience.

Clinician I shall mean an individual with a minimum of a masters degree in any of the disciplines mentioned under Clinical Supervisor and who has a minimum of four years of counseling experience, one year of which shall have been related to substance abuse. If providing supervision, one year of supervisory experience is also required.

Clinician II shall mean an individual with a minimum of a masters degree in any of the disciplines mentioned under Clinical Supervisor and who has a minimum of two years of counseling experience, or has a bachelors degree in any of the disciplines mentioned above and a minimum of three years of substance abuse counseling experience, or is a Registered Nurse with a minimum of three years medical and/or counseling experience related to substance abuse treatment, or has alcohol or drug counselor certification and a minimum of five years of substance abuse counseling experience.

Clinician III shall mean an individual witb a minimum of a high school degree or equivalent and a minimum of one year supervised counseling experience in substance abuse treatment or a closely related field.

160.020: continued

Commissioner shall mean the Commissioner of Public Health.

Consultation shall mean the presentation of specific patient cases to clinicians of equal or greater expertise for the purpose of feedback, direction and guidance.

Department shall mean the Department of Public Health.

License shall mean certification, in writing, whether full or provisional, issued by the Department to any responsible and suitable agency which authorizes that agency to operate a medical detoxification treatment service.

Licensed Practical Nurse shall mean an individual licensed by Massachusetts Board of Registration in Nursing in accordance with M.G.L. c. 112, § 74A, and knowledgeable in the field of alcoholism and drug addiction.

Licensee shall mean any agency holding a license or approval from the Department to operate the service.

Medical Director shall mean a physician who assumes responsibility for the administration of all medical services performed by the service.

Nurse Practitioner shall mean an individual licensed in accordance with M.G.L. c. 112, § 80B and knowledgeable in the field of alcoholism and drug addiction.

Nurse Supervisor shall mean a registered nurse with a minimum of three years nursing experience, of which one year shall have been related to substance abuse treatment.

Patient shall mean a person applying for admission or admitted to the service.

Physician shall mean an individual licensed by the Massachusetts Board of Registration in Medicine in accordance with M.G.L. c. 112, § 2, and knowledgeable in the field of alcoholism and drug addiction.

Physician Assistant shall mean an individual licensed in accordance with M.G.L. c. 112, § 9G and knowledgeable in the field of alcoholism and drug addiction.

Psychiatrist shall mean a physician licensed by the Massachusetts Board of Registration in Medicine; certified by the American Board of Psychiatry and Neurology or an equivalent body, or eligible for such certification, and knowledgeable in the field of alcoholism and drug addiction.

Psychologist shall mean an individual licensed by the Massachusetts Board of Registration of Psychologists in accordance with M.G.L. c. 112, §§ 118 through 129; and knowledgeable in the field of alcoholism and drug addiction.

Qualified Health Care Professional shall mean a Registered Nurse, Licensed Practical Nurse trained to do physical assessments, Nurse Practitioner or Physician's Assistant duly licensed, certified or registered as such in the Commonwealth of Massachusetts.

Registered Nurse shall mean an individual licensed by the Massachusetts Board of Registration in Nursing in accordance with M.G.L. c. 112, § 74, and knowledgeable in the field of alcoholism and drug addiction.

The Service shall mean an acute care inpatient substance abuse detoxification service.

Social Worker shall mean an individual licensed by the Massachusetts Board of Registration of Social Workers in accordance with M.G.L. c. 112, §§ 130 through 138, and knowledgeable in the field of alcoholism and drug addiction.

160.020: continued

Staff shall mean an individual designated by the agency to provide the service on a direct or indirect basis.

Supervision shall mean a regular and specified time set aside to provide training, education and guidance to clinical staff in the management of their clinical cases. Supervision may be provided one-to-one or in small groups of no more than eight individuals.

160.097: Compliance with Requirements

Unless otherwise provided all acute care inpatient substance abuse detoxification treatment services licensed or approved pursuant to 105 CMR 160.000 shall meet the requirements set forth in 105 CMR 160.000.

160.098: Waiver

(A) The Commissioner or his/her designee may waive the applicability of one or more of the requirements imposed on the service by 105 CMR 160.000 upon finding that:

(1) Compliance would cause undue hardship to the agency;

(2) The agency is in substantial compliance with the spirit of the requirement; and

(3) The agency's non-compliance does not jeopardize the health or safety of its patients and does not limit the agency's capacity to provide the service.

(B) The agency shall provide the Commissioner or his/her designee written documentation supporting its request for a waiver.

160.099: Severability

Any section, subsection, paragraph or provision of 105 CMR 160.000 declared illegal or unconstitutional by a court of competent jurisdiction is severable from 105 CMR 160.000

160.100: Requirement of Licensure and Approval

(A) Agencies Requiring Licensure or Approval.

(1) All agencies shall file an application for licensure or approval with the Department for the establishment or provision of the service.

(2) Where the service is established and provided by a application for approval for the establishment or provision of the service shall be filed.

(B) Agencies Not Requiring Licensure or Approval. A service established and provided by a department, agency or institution of the federal government does not require licensure or approval under 105 CMR 160.000.

160.101: Application for a License or Certificate of Approval

(A) Applicants for a license or certificate of approval shall submit to the Department an application on an approved form obtained from the Department together with such other documents and materials as the Department shall deem appropriate.

(B) No application shall be accepted unless it is on Department forms, completed in full, and sworn and attested to before a notary.

(C) Any and all fees for the license shall accompany each application and shall be in the amount set by the Department or the Executive Office of Administration and Finance. No fee shall be required of a department, agency or institution or political subdivision of the Commonwealth applying for a certificate of approval.

160.102: Evaluation of Application

The Department shall not approve an application for an initial or renewal license or approval unless: